

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 3 - 0 1 1

2. STATE:

Iowa

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

July 1, 2003

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.53

7. FEDERAL BUDGET IMPACT:

a. FFY 03 \$ ~~(354)~~ (537)

b. FFY 04 \$ ~~(3416)~~ (2,139)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.18-A, pages 1, 1a, & 1b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

Attachment 4.18-A, pages 1 & 1a

10. SUBJECT OF AMENDMENT:

Revises current copayment and adds a copayment for physician office visits

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ OTHER, AS SPECIFIED:

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Kevin W. Concannon

13. TYPED NAME:

Kevin W. Concannon

14. TITLE:

Director

15. DATE SUBMITTED:

August 8, 2003

16. RETURN TO:

Director

Iowa Department of Human Services

Hoover State Office Building, 5th Floor

Des Moines, Iowa 50319

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

08/12/03

18. DATE APPROVED:

AUG 01 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

JUL 01 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

Thomas W. Lenz

21. TYPED NAME:

Thomas W. Lenz

22. TITLE:

Assistant Regional Administrator for DMCH

23. REMARKS:

SPA CONTROL

Date Submitted: 08/08/03

Date Received: 08/12/03

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: IOWA

- A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Services	Type of Charge			Amount and Basis for determination
	Deduct.	Coins.	Copay.	
Prescribed Drugs			X	\$1.00 for each covered generic prescription, including each refill, and \$0.50 for each covered brand-name drug prescription, including each refill, for which the cost to the state is \$10.00 or less, and \$1.00 for each covered brand-name drug prescription, including each refill, for which the cost to the state is \$10.01 to \$25.00, and \$2.00 for each covered brand-name drug prescription, including each refill, for which the cost to the state is \$25.01 to \$50.00, and \$3.00 for each covered brand-name drug prescription, including each refill, for which the cost to the state is \$50.01 or more.
Chiropractors			X	\$1.00 for total amount of service provided during a given date.*
Independently practicing physical therapist			X	\$1.00 for total amount of service provided during a given date.*

TN No: MS-03-11
Supersedes
TN No. MS-91-54

Approval Date MAR 03 2004

Effective Date JUL 01 2003
HCFA ID: 0053C/0061E

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Services	Type of Charge			Amount and Basis for determination
	Deduct.	Coins.	Copay.	
Podiatrists			X	\$1.00 for total amount of service provided during a given date.*
Medical equipment and appliances, prosthetic devices and sickroom supplies			X	\$2.00 for total amount of service provided during a given date.*
Orthopedic shoes			X	\$2.00 for total amount of service provided during a given date.*
Audiologists services (including medical supplies provided by the audiologist but excluding hearing aids)			X	\$2.00 for total amount of service provided during a given date.*
Optometrists			X	\$2.00 for total amount of service provided during a given date.*
Opticians			X	\$2.00 for total amount of service provided during a given date.*

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Services	Type of Charge			Amount and Basis for determination
	Deduct.	Coins.	Copay.	
Rehabilitation agencies			X	\$2.00 for total amount of service provided during a given date.*
Psychologists			X	\$2.00 for total amount of service provided during a given date.*
Ambulance services			X	\$2.00 for each date of service*
Dental services			X	\$3.00 for total amount of service provided during a given date.*
Hearing Aids			X	\$3.00 for total amount of service provided during a given date.*
Physician office visits			X	\$3.00 for total covered services provided in a physician office visit, rendered on a given date of service.** For purposes of this provision, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.)
* The basis for the copayment is the statewide average payment for all service provided one recipient by one provider on a single date. Averages were computed from claims paid during fiscal year 1982.				
** The basis for the copayment is the statewide average payment for all service provided one recipient by one provider on a single date. Averages were computed from claims paid during state fiscal year 2003.				

TN No: MS-03-11

Supersedes

TN No. None

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TN No: MS-03-11 (substitute page)

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